The Journey to Value-Based Care and Population Health

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What is the future of value-based care?
The imperative to lower costs and improve quality will not change

Growing annual health care costs per American

- 20 years ago: $2.8K
- 10 years ago: $4.7K
- Today: $10.3K

Growing Medicare payments tied to quality

- 2015: 20%
- 2016: 30%
- 2018: 50%

Growing Medicare payments tied to risk

- 2015: 80%
- 2016: 85%
- 2018: 90%
The path and timing to transformation will vary

**THE INTENDER**
*Laying the foundation*
- Protecting
- Physician loyalty

**THE BUILDER**
*Gaining risk experience*
- Learning by trial and error
- Experiencing failures and successes

**THE ADVANCER**
*Scaling for growth*
- Repeating success with payer-involved risk contracts
- Building scale with population health success
- Meaningful reductions in cost of care

**THE DISRUPTER**
*Leading markets*
- Partnering and sharing results across entire continuum
- Cutting edge integrated resources and models get cutting edge results
Framework for value-based care

1. Value-based care strategy
   Growth channels | Value-based entity | Road map | Leadership and governance | Financial pro forma
2. High-performance network management
3. Population health management and quality
4. Enterprise risk and financial management
5. Data management
6. Consumer engagement
7. Analytics and reporting
8. Enabling technology
9. Business operations excellence
10. Product leadership
11. Organizational change and talent acceleration
There are minimum requirements for success

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<th>Risk management and growth strategy</th>
<th>Network formation and contracting</th>
<th>Integrated care delivery</th>
<th>Integrated partnership</th>
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<td>Craft a sustainable value-based strategy with a solid financial foundation for profitability and growth.</td>
<td>Develop an aligned physician network; match cross continuum and regional partnerships to market opportunities.</td>
<td>Develop and implement comprehensive, customized, scalable and standardized clinical programs and services.</td>
<td>Develop partnerships, centralized infrastructure and local market governance to drive efficient operations. Integrate data and analysis and drive patient health at lower costs.</td>
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Leading the right pace with the right capabilities

Transformation Capabilities Across the Continuum

**The Intender**
- Risk management and growth strategies

**The Builder**
- Data and analytics

**The Advancer**
- Gaining risk experience
  - Pop health, risk adjustment, performance management, risk contracts

**The Disrupter**
- Scaling for growth
  - Maturing partnerships, aggregating lives under contracts

**Leading markets**
- Payer and provider alliances; provider sponsored health
- Fully delegated services and financial risk

Laying the foundation
- CIN formation, strategy, and risk analytics
Implementing a Data-Driven Population Health Strategy:
The Temple Center for Population Health
Value-based care strategy
Path to continued growth

Focus on three levers of VBC growth

1. **Grow** number of attributed lives under existing contracts

2. **Expand** scale and scope of incentives under existing or new contracts (clinically integrated networks)

3. **Explore** new VBC arrangements and programs with governmental/ commercial payers and/or large employers
Temple Center for Population Health
Value-based strategies

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Utilizing analytics to drive action

Using analytics to drive population care management

- **Attributed lives**: Risk strat attributed population
- **Healthy/minor acute**: Segment population
- **Chronic**: Complex chronic
- **Preventive**: Risk strat population segments
- **Rising risk**: Identified high/rising risk members triaged by care navigator and managed via defined care pathways
Population segmentation

**Phase I:** Maintain focus on med-high/high risk with emphasis on supplemental income adults with chronic conditions

**Phase II:** Expand to cover all segments of initial risk contracts

**Future state:** Expand segmentation to cover all populations in all risk contracts

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**Legend:**
- *Multimodal disease management (e.g., education, online engagement, remote monitoring); Other allied support: social worker, pharmacist/medication mgmt, educator, dietitian)
- Lead provider

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**Phase I:**
- Concentrate on med-high/high risk with emphasis on supplemental income adults with chronic conditions

**Phase II:**
- Expand to cover all segments of initial risk contracts

**Future state:**
- Expand segmentation to cover all populations in all risk contracts

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**Resources**
- **High**
  - Healthy/Minor Acute + Normal Pregnancy
  - Chronic
  - Complex Chronic
  - Major Acute + High-Risk OB/NICU
  - End of Life

- **Low**
  - Care Intensity
  - **More**
  - **Less**

**Legend:**
- Mid-level provider
- PCP
- Specialist
- Nurse navigator/CHW
- BH specialists
- Other allied support
- Palliative care
- Multimodal disease management

**Source:** 10000 Lives Model of Population Health Care Delivery
Chronic care analysis (under $200,000 threshold)

For chronic disease claims under $200,000, a 18.2% increase in PMPY occurs year-over-year.

Proportion of total spend allocated to chronic care increased by 11% from Year 1 to Year 2.

Conclusion
With a significant increase in PMPY for chronic disease claims, the analysis suggests that chronic disease is a key driver of year-over-year under $200,000 spend trends.
## Transformation: Heart Failure Medical Neighborhood

### Community

#### Secondary Clinical

**Primary Clinical**

- **Patient-centered medical home**
- **Care management**
  - Nurse navigator, community health worker, pharmacist, dietician/nutritionist
- **Family**
- **Primary/specialty care**
  - Family practice/internal medicine physician or cardiologist

**Pharmacy/DME**

- Medication management and reconciliation (e.g., diuretic, Beta blocker, ACE inhibitor)
- Defibrillator, pacemakers, blood pressure, and pulse oximeter education

**Specialty and Palliative Care**

- Complex patient management by CHF program/clinic, with co-management by cardiologist, electrophysiologist, and cardiovascular surgeon
- Advanced illness/end-of-life support, including palliative care, hospice, advance directives, POLST/MOLST

**Virtual Health**

- Remote patient monitoring of biomarkers (e.g., scale, HR and activity monitors, and other wearable devices) connecting home health and lead physician
- Telehealth access to providers

**Acute Care**

- Episodic acute care at hospitals, emergency departments, and urgent care centers

**Post-acute Care**

- Cardiac rehabilitation and other post-acute care sites (SNFs, LTACs, and Home Health agencies)
- Home Health connectivity with patient monitoring devices
- Coordination with care management team to manage transitions

**Workplace, religious organizations and community locations**

- HF risk screening (e.g., 6 for Life)
- Heart failure support groups
- Smoking cessation programs
- Dietary counseling
- Weight management services

**Community and public health agencies**

- Assistance program enrollment (e.g., SNAP)
- Transportation services
- Permanent and supportive housing assistance programs (e.g., Blueprint Voucher Program, Pathways to Housing PA, etc.)
Expanding VBC contracts with payers

A best practice risk-based contracting strategy ensures that incremental risk/rewards are **proactively incorporated** into contracts and reflect metrics/performance drivers that are **identifiable and addressable** through care management.

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<th>Actuarial driven</th>
<th>Process based</th>
<th>Strategically aligned</th>
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| • Actuarial analytics/expertise to identify modifiable risk  
  • Service inclusions/exclusions  
| • Claims data management and validation  
  • Templates to drive contracting consistency  
| • Alignment with VBC strategy and capabilities  
  • Standardized quality metrics across contracts |
Data-driven value
The business model for population health

Value-based population health requires real time, actionable data that drive alternative health care delivery models, population health management methods, incentives and reimbursement models that ultimately improve health outcomes.

The Triple Aim
- Healthier people
- Smarter spending
- Better care

Payment models

VALUE
DATA

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The only thing we know about the future is that it will be different.

– Peter Drucker
Thank you

We acknowledge the Population Health teams at the Temple Center for Population Health and Optum for their contributions.